National Health Spending In 2006: A Year Of Change For Prescription Drugs

The rate of prescription drug spending increased for the first time in several years, and Medicare Part D caused some major shifts in the payer landscape.

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ABSTRACT: In 2006, U.S. health care spending increased 6.7 percent to $2.1 trillion, or $7,026 per person. The health care portion of gross domestic product (GDP) was 16.0 percent, slightly higher than in 2005. Prescription drug spending growth accelerated in 2006 to 8.5 percent, partly as a result of Medicare Part D's impact. Most of the other major health care services and public payers experienced slower growth in 2006 than in prior years. The implementation of Medicare Part D caused a major shift in the distribution of payers for prescription drugs, as Medicare played a larger role in drug purchases than it had before. [*Health Affairs* 27, no. 1 (2008): xx–yy; 10.1377/hlthaff.27.1.xx]

HEALTH CARE SPENDING IN THE UNITED STATES grew 6.7 percent to $2.1 trillion, or $7,026 per person, in 2006 (Exhibits 1 and 2). This rate of growth was slightly faster than the 6.5 percent rate in 2005, which marked the slowest growth since 1999. Health spending accounted for 16.0 percent of gross domestic product (GDP) in 2006. This share has remained relatively stable since 2003 as a result of slower health spending growth (which peaked in 2002 at 9.1 percent) and relatively strong U.S. economic growth, which has increased more than 6 percent each year since 2004. In 2006, health spending growth outpaced nominal GDP growth by 0.6 percentage point.

This paper presents a comprehensive view of national health spending through 2006. Spending trends are disaggregated by type of service, source of funds, and sponsor; the analysis focuses primarily on the most recent years. In 2006, several important findings emerged. First, after six consecutive years of slowing growth, prescription drug spending growth accelerated in 2006. At the same time, imple-

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DOI 10.1377/hlthaff.27.1.1

EXHIBIT 1
National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1970–2006

Spending category	1970	1980	1990	2000	2003	2004	2005	2006
NHE, billions	$74.9	$253.4	$714.0	$1,353.6	$1,732.4	$1,852.3	$1,973.3	$2,105.5
Health services and supplies	67.1	233.4	666.7	1,264.8	1,620.7	1,730.6	1,843.6	1,966.2
Personal health care (PHC)	62.9	214.8	607.5	1,139.6	1,445.9	1,547.7	1,653.7	1,762.0
Hospital care	27.6	101.0	251.6	417.1	525.4	564.4	605.5	648.2
Professional services	20.6	67.3	216.8	426.7	542.9	580.7	622.2	660.2
Physician and clinical services	14.0	47.1	157.5	288.6	366.7	393.6	422.6	447.6
Other prof. services	0.7	3.6	18.2	39.1	49.0	52.4	56.2	58.9
Dental services	4.7	13.3	31.5	62.0	76.9	81.5	86.6	91.5
Other PHC	1.2	3.3	9.6	37.0	50.3	53.2	56.8	62.2
Home health and nursing home care	4.3	20.9	65.2	125.8	148.5	157.9	168.7	177.6
Home health care[a]	0.2	2.4	12.6	30.5	38.0	42.7	47.9	52.7
Nursing home care[a]	4.0	18.5	52.6	95.3	110.5	115.2	120.7	124.9
Retail outlet sales of medical products	10.5	25.7	74.0	170.1	229.0	244.7	257.3	276.0
Prescription drugs	5.5	12.0	40.3	120.6	174.2	188.8	199.7	216.7
Durable medical equipment	1.6	3.8	11.2	19.3	22.4	22.8	23.2	23.7
Other nondurable medical products	3.3	9.8	22.5	30.2	32.4	33.1	34.4	35.6
Program administration and net cost of private health insurance	2.8	12.2	39.2	81.8	121.0	129.0	133.6	145.4
Government public health activities	1.4	6.4	20.0	43.4	53.8	53.9	56.3	58.7
Investment	7.8	19.9	47.3	88.8	111.8	121.7	129.7	139.4
Research[b]	2.0	5.4	12.7	25.6	35.5	38.8	40.6	41.8
Structures and equipment	5.8	14.5	34.7	63.2	76.3	83.0	89.1	97.6
Population (millions)	210.2	230.4	253.8	282.6	291.1	294.0	296.8	299.7
NHE per capita	$356	$1,100	$2,813	$4,790	$5,952	$6,301	$6,649	$7,026
GDP, billions of dollars	$1,039	$2,790	$5,803	$9,817	$10,961	$11,686	$12,434	$13,195
NHE as percent of GDP	7.2%	9.1%	12.3%	13.8%	15.8%	15.9%	15.9%	16.0%
Implicit price deflator for GDP	27.5	54.0	81.6	100.0	106.4	109.5	113.0	116.6
Real GDP, billions of dollars	$3,771	$5,161	$7,112	$9,817	$10,301	$10,675	$11,003	$11,319
Real NHE[c], billions of dollars	$272	$468	$875	$1,353	$1,628	$1,692	$1,746	$1,806
Personal health care deflator[d]	16.0	34.5	70.4	100.0	111.8	116.3	120.4	124.5

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

[a] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

[b] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

[c] Deflated using the implicit price deflator for GDP (2000 = 100.0).

[d] Personal health care (PHC) implicit price deflator is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

mentation of Medicare Part D caused major shifts in the sources of funds used to pay for drugs. Additionally, these shifts and the movement toward greater enrollment in Medicare managed care plans caused the growth in Medicare's administrative and net cost of insurance to accelerate. Beyond these factors, a broadly based slowdown across most of the major health care services and public payers more than offset a slight acceleration in spending growth from private payers. The slowdown in personal health care spending is more pronounced when trends in

EXHIBIT 2
National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 1970–2006

Spending category	1970[a]	1980	1990	2000	2003	2004	2005	2006
NHE	10.5	13.0	10.9	6.6	8.6	6.9	6.5	6.7
Health services and supplies	10.4	13.3	11.1	6.6	8.6	6.8	6.5	6.6
Personal health care (PHC)	10.4	13.1	11.0	6.5	8.3	7.0	6.8	6.6
Hospital care	11.6	13.9	9.6	5.2	8.0	7.4	7.3	7.0
Professional services	9.5	12.5	12.4	7.0	8.4	7.0	7.1	6.1
Physician and clinical services	10.1	12.9	12.8	6.2	8.3	7.3	7.4	5.9
Other prof. services	6.6	17.1	17.5	8.0	7.8	7.0	7.1	4.9
Dental services	9.1	11.1	9.0	7.0	7.4	6.0	6.3	5.7
Other PHC	7.3	10.1	11.4	14.5	10.7	5.7	6.8	9.5
Home health and nursing home care	17.2	17.2	12.1	6.8	5.7	6.3	6.9	5.3
Home health care[b]	14.5	26.9	18.1	9.3	7.6	12.3	12.3	9.9
Nursing home care[b]	17.4	16.4	11.0	6.1	5.1	4.2	4.9	3.5
Retail outlet sales of medical products	7.8	9.4	11.2	8.7	10.4	6.8	5.2	7.3
Prescription drugs	7.5	8.2	12.8	11.6	13.0	8.4	5.8	8.5
Durable medical equipment	9.7	8.9	11.4	5.6	5.1	1.5	1.7	2.3
Other nondurable medical products	7.4	11.4	8.6	3.0	2.4	2.1	4.0	3.5
Program administration and net cost of private health insurance	8.6	16.0	12.4	7.6	14.0	6.6	3.6	8.8
Government public health activities	12.8	16.5	12.0	8.1	7.4	0.2	4.4	4.3
Investment	11.7	9.9	9.0	6.5	8.0	8.9	6.6	7.4
Research[c]	10.9	10.8	8.9	7.3	11.5	9.1	4.8	2.9
Structures and equipment	11.9	9.5	9.1	6.2	6.5	8.8	7.4	9.5
Population	1.2	0.9	1.0	1.1	1.0	1.0	1.0	1.0
NHE per capita	9.2	11.9	9.8	5.5	7.5	5.9	5.5	5.7
GDP	7.0	10.4	7.6	5.4	3.7	6.6	6.4	6.1
Implicit price deflator for GDP	2.7	7.0	4.2	2.1	4.7	2.9	3.2	3.2
Real GDP, billions of chained dollars	4.2	3.2	3.3	3.3	2.1	3.6	3.1	2.9
Real NHE,[d] billions of dollars	7.6	5.6	6.4	4.5	1.6	3.9	3.2	3.4
Personal health care deflator[e]	4.1	8.0	7.4	3.6	6.4	4.1	3.5	3.3

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

[a] Average annual growth, 1960–1970.

[b] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

[c] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

[d] Deflated using the implicit price deflator for GDP (2000 = 100.0).

[e] Personal health care (PHC) implicit price deflator is constructed from the Producer Price Index for hospital care, Nursing Home Input Price Index for nursing home care, and Consumer Price Indices specific to each of the remaining PHC components.

prescription drugs are excluded, decelerating from 7.0 percent in 2005 to 6.3 percent in 2006 (Exhibit 3).[1] By comparison, overall personal health care spending, including prescription drugs, slowed just 0.2 percentage point.

Retail Drug Spending: Current Trends And Funding

The retail prescription drug market experienced major changes in 2006 as full implementation of the Medicare Part D drug benefit affected overall growth and

EXHIBIT 3
Annual Percentage Change In Personal Health Care Spending, With And Without Prescription Drugs, 2005 And 2006

	Including drugs (%)		Excluding drugs (%)	
	2005	2006	2005	2006
Personal health care	6.8	6.6	7.0	6.3
Private	6.4	5.4	6.4	6.6
PHI	6.9	6.0	7.0	7.3
OOP	5.2	3.8	5.1	5.3
Other	6.4	5.4	6.4	5.4
Public	7.5	8.0	7.6	5.9
Medicare	9.1	16.9	9.0	6.0
Medicaid	7.3	−1.3	8.0	5.6
Other	3.6	6.5	3.0	6.1

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
NOTE: PHI is private health insurance. OOP is out of pocket.

changed the mix of payers. Growth in retail drug spending accelerated in 2006 to 8.5 percent from a recent low of 5.8 percent in 2005, the slowest rate of growth in drug spending since 1977 (Exhibit 2). The 2006 trend was influenced primarily by increased use and other nonprice factors that outweighed relatively stable drug price growth. Despite this acceleration, the 2006 growth was still well below the average annual rate of 13.4 percent per year between 1995 and 2004.

The use of prescription drugs, as measured by the number of prescriptions purchased, increased more rapidly in 2006 than in 2005.[2] As a result, growth in use accounted for roughly half of the growth in drug spending in 2006, compared with about 20 percent of growth in 2005. Some of this increased use can be attributed to the implementation of Medicare Part D. A recent survey indicated that in 2006, as expected, seniors with drug coverage, either Medicare Part D plans or other insurance, used more prescription drugs and were more likely to fill a prescription than seniors without drug coverage.[3] Other factors influencing the increased use of prescription drugs in 2006 included new indications for existing drugs, strong growth in several therapeutic classes, and increased use of specialty drugs.[4] The impact of newly approved drugs was somewhat limited in 2006, in part because many of those products were introduced into the market late in the year.[5] However, several drugs approved and introduced in 2004 and 2005 contributed to the growth in use in 2006, particularly among hypnotics (insomnia drugs), which experienced faster growth in use than any other class of drugs.[6]

Changes in the mix of drugs (brand versus generic, and therapeutic mix), lower overall rebates, and increases in the average units per prescription also contributed to the 2006 growth in drug spending. The generic dispensing rate reached 63 percent in 2006, up from 56 percent in 2005.[7] The generic drug trend was primar-

ily influenced by the following factors: (1) the continued use of incentives such as tiered copayment structures, copayment waivers, and step therapy, which encourage the use of generic drugs; (2) the loss of patent protection for a number of brand-name drugs that became available in generic form in 2006—most notably, Zocor, Zoloft, Pravachol, and Flonase; and (3) the lack of new blockbuster drugs.[8] This increased use of generic drugs, which on average have a much lower price than similar brand-name drugs, helped restrain drug spending growth in 2006.

Lower overall rebates from drug manufacturers contributed positively to the growth in prescription drug spending in 2006. Several factors appear to be influencing this overall effect. First, drug coverage for people who are dually eligible for Medicaid and Medicare was transferred from Medicaid to Medicare in 2006, as a result of Part D. Under laws enacted in each state, drug manufacturers must provide relatively substantial rebates to state Medicaid programs. In practice, rebates negotiated by health insurance plans are generally lower than these mandated levels. Conversely, rebates now exist for some new Part D enrollees that did not previously have drug coverage through Medicaid, employer-sponsored retiree health plans, or other forms of group insurance. On balance, the reduction in rebates for the large number of dually eligible beneficiaries appears to have outweighed the increase in rebates for newly insured enrollees under Part D. Finally, in 2006, drug use continued to shift from brand-name prescriptions to generics, which seldom have rebates; therefore, this lowered aggregate rebate amounts.

Shifts in the therapeutic mix, which can be defined as changes in the relative shares of drugs within a class or among classes or new strengths of existing drugs, contributed to the faster growth in retail prescription drug spending in 2006.[9] In addition, some reports indicate that increases in the average number of units per prescription contributed positively to 2006 growth (this component of use is not captured by the number of prescriptions purchased).[10]

Prescription drug prices, as measured in the National Health Expenditure Accounts (NHEA), grew similarly in 2005 and in 2006, at 3.5 percent (data not shown). The 2006 rate was 0.8 percentage point lower than the published Consumer Price Index (CPI) for prescription drugs, which did not reflect the movement to Medicare Part D coverage of beneficiaries who previously lacked drug coverage or were only partially insured.[11] The emergence of generic prescription drug discount programs by several retail outlets, most notably Wal-Mart in late 2006, also contributed to the stabilization of price growth, although the impact of these programs was limited because of their late-in-the-year introduction.

Impact Of Part D On Sources Of Funding And Sponsors

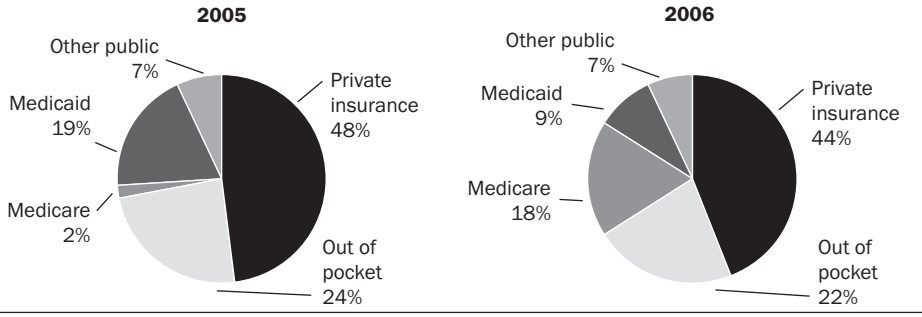
The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 changed the health care financing landscape by implementing the Medicare Part D drug benefit. Under Part D, aged and disabled Medicare beneficiaries in 2006 had access to prescription drug coverage through stand-alone pre-

scription drug plans (PDPs), Medicare Advantage prescription drug (MA-PD) plans, or Medicare-subsidized employer plans. Those who had third-party drug coverage before Part D took effect were covered by Medicaid, private insurance (Medigap and employer-sponsored plans), state assistance programs, Medicare managed care plans, or other government programs, while those without drug coverage paid for drugs directly out of pocket. The great majority of Medicare beneficiaries who are not enrolled in PDPs and MA-PD plans or subsidized employer plans have drug coverage through federal or military retirement health plans.

The impact of Part D on overall national health care spending in 2006 was modest; however, Part D had a substantial impact on the sources of funds used to pay for prescription drugs and the sponsors of those payments. The public share of drug spending increased from 28 percent in 2005 to 34 percent in 2006, while the private share fell from 72 percent to 66 percent (Exhibit 4).[12] The impact of this shift in funding was considerable for the Medicare and Medicaid programs. The Medicare share of total retail prescription drug spending increased from just 2 percent in 2005 to 18 percent in 2006. For the Part D benefit, roughly 87 percent of expenditures ($35.7 billion of $41.0 billion) were for direct drug purchases; the remaining 13 percent is reported in the NHEA as government administration and net cost of insurance. At the same time, Medicaid drug spending fell as a share of total drug spending, from 19 percent in 2005 to 9 percent in 2006. This decline was primarily attributable to the automatic enrollment of 6.2 million dually eligible people into Medicare Part D plans and, to a lesser extent, to continued efforts by states to contain their Medicaid drug costs.[13]

Both out-of-pocket and private health insurance spending for drugs fell as a share of total drug spending in 2006. Out-of-pocket spending fell from a 24 percent share in 2005 to 22 percent in 2006, while private health insurance spending fell from a 48 percent share in 2005 to 44 percent in 2006. Interestingly, out-of-pocket drug spending declined by 2.4 percent in 2006—more steeply than the 0.7

EXHIBIT 4
Sources Of Funds For Retail Prescription Drugs, 2005 And 2006



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
NOTES: Numbers might not add to 100 percent because of rounding. "Other public" includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, state and local hospital subsidies, and school health.

percent decline in drug spending paid for by private insurance (data not shown).

Analysis of health spending by sponsor (businesses, households, governments, or other private sponsors) can provide a more complete understanding of the impact of Medicare Part D's implementation. In the NHEA, a distinction is drawn between the sponsor and the purchaser of health care goods and services (purchasers are sources of funding such as third-party insurers, including public programs, and individuals' out-of-pocket payments).[14] For example, Medicare Part D and MA premiums paid by beneficiaries are allocated to household spending in the sponsor analysis and to Medicare in the source-of-funding analysis. Similarly, state phase-down payments are included in Medicare in the source-of-funding analysis but are allocated to state government spending in the sponsor analysis. Finally, the Medicare retiree drug subsidy is reflected in private health insurance (for private and state and local government employers) when health spending is analyzed by sources of funding and allocated to federal government spending when spending is analyzed by sponsor.

At the aggregate sponsor level in 2006, businesses (25 percent), households (31 percent), other private revenues (3 percent), the federal government (23 percent), and state and local governments (17 percent) paid for about the same share of health services and supplies as they did in 2005 (Exhibit 5). However, there were noticeable shifts within sponsor categories related to the implementation of Medicare Part D. Medicare increased from 29 percent of federal spending in 2005 to 34 percent in 2006, while Medicaid decreased from 45 percent to 40 percent. These shifts were attributable to the automatic enrollment of dually eligible beneficiaries in Medicare Part D plans but were largely offsetting at the aggregate federal sponsor level because both programs were still being financed by general revenues. Similarly, state and local governments sponsored roughly the same proportions of health spending in 2006; however, Medicaid spending accounted for a smaller share of state and local spending (43 percent in 2005 versus 41 percent in 2006). At the same time, state and local government spending for other health programs increased from 23 percent in 2005 to 26 percent in 2006 (Exhibit 5). This increase was largely attributable to the combined effects of dually eligible beneficiaries moving from Medicaid drug coverage to Medicare Part D (which lowered state Medicaid spending) and state phase-down payments (which were paid for out of non-Medicaid state and local budgets). For households, payroll taxes and premiums to Medicare became a slightly larger share of household spending in 2006 (24 percent versus 22 percent in 2005), in part because of Part D premiums that were paid for the first time. Finally, household out-of-pocket spending fell as a share of total household spending, in part because of the increased number of elderly people with drug coverage (Medicare Part D).

Growth Slows In 2006 For Most Major Services And Payers

Despite faster growth in retail prescription drug spending and a slight accelera-

EXHIBIT 5
Expenditure Levels And Distributions For Health Services And Supplies, By Type Of Sponsor, Selected Calendar Years 1987–2006

	Expenditures ($ billions)				Distribution (%)			
Type of sponsor	**1987**	**2000**	**2005**	**2006**	**1987**	**2000**	**2005**	**2006**
Health services and supplies	477.8	1,264.8	1,843.6	1,966.2	100	100	100	100
Business, household, and other private	333.4	821.6	1,110.5	1,176.5	70	65	60	60
Business	122.1	342.4	470.1	496.8	26	27	25	25
Employer contributions to private health insurance premiums	84.2	251.1	360.4	381.8	69	73	77	77
Other[a]	37.9	91.3	109.7	115.6	31	27	23	23
Household	188.9	425.4	575.7	611.6	40	34	31	31
Household private health insurance premiums[b]	43.9	133.6	203.0	211.3	23	31	35	35
Medicare payroll taxes and premiums[c]	35.7	98.8	125.6	143.8	19	23	22	24
Out-of-pocket health spending	109.2	192.9	247.1	256.5	58	45	43	42
Other private revenues	22.4	53.8	64.8	68.2	5	4	4	3
Government	144.4	443.2	733.1	789.6	30	35	40	40
Federal government	73.9	235.7	411.6	449.5	15	19	22	23
Employer contributions to private health insurance premiums	4.9	14.3	23.1	24.3	7	6	6	5
Employer payroll taxes paid to Medicare HI Trust Fund	1.7	2.7	3.4	3.5	2	1	1	1
Medicare[d]	16.9	48.9	118.6	152.9	23	21	29	34
Medicaid[e]	28.1	119.8	184.0	181.3	38	51	45	40
Other programs[f]	22.3	50.1	82.4	87.5	30	21	20	19
State and local government	70.5	207.5	321.5	340.2	15	16	17	17
Employer contributions to private health insurance premiums	16.0	56.0	99.0	104.6	23	27	31	31
Employer payroll taxes paid to Medicare HI Trust Fund	3.1	7.5	9.4	9.9	4	4	3	3
Medicaid[e]	22.8	85.4	138.0	138.9	32	41	43	41
Other programs[g]	28.6	58.7	75.1	86.8	41	28	23	26

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

[a] Includes employer Medicare Hospital Insurance (HI) payroll taxes, temporary disability insurance, workers' compensation, and industrial in-plant (employer-provided health units).

[b] Includes employee contributions to employer-sponsored and individually purchased health insurance.

[c] Includes employee and self-employment payroll taxes and premiums paid to Medicare HI and Supplementary Medical Insurance (SMI) Trust Funds.

[d] The data for federal government Medicare equal Trust Fund interest income and federal general revenue contributions to Medicare less the net change in the Trust Fund balance.

[e] Includes State Children's Health Insurance Program (SCHIP) expansion.

[f] Includes maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, federal workers' compensation, and other miscellaneous general hospital and medical programs, public health activities, Department of Defense, and Department of Veterans Affairs.

[g] Includes state phase-down payments, maternal and child health, public and general assistance, vocational rehabilation, state/local hospital subsidies, public health activities, and SCHIP.

tion in overall health spending, most major health services and public payers experienced slower growth in 2006. Personal health care (PHC), the portion of national health spending that accounts for health care goods and services, grew 6.6 percent in 2006, following growth of 6.8 percent in 2005 (Exhibit 2).[15] This

growth can be disaggregated into its underlying factors: health care price, population, and residual growth (primarily changes in the use and intensity of medical care services per person). The relative contributions of these factors in 2006 were similar to those in 2004 and 2005. Health care price growth accounted for more than half of the growth in 2006; population growth, for almost one-sixth; and residual real per capita growth, for the remaining one-third.[16] The impact of trends in price and nonprice factors varied within each service or goods category.

■ **Hospitals.** In 2006, hospital spending grew 7.0 percent to $648.2 billion, a slowdown of 0.3 percentage point from 2005, continuing a gradual deceleration from 8.2 percent growth in 2002 (Exhibits 1 and 2). Growth in the use of hospital services remained low and was partly offset by an uptick in hospital price growth. Medicare inpatient spending growth slowed greatly in 2006 as growth in fee-for-service (FFS) inpatient admissions declined.[17] Medicaid hospital use slowed as well, in part because of slower enrollment growth.

Hospital price growth, as measured by the Producer Price Index (PPI), increased 4.4 percent in 2006 compared to 3.8 percent in 2005.[18] In contrast to hospital transaction prices, the underlying costs of providing hospital services captured by the hospital input price index showed slightly slower growth of 4.1 percent in 2006, following a 4.3 percent increase in 2005.[19] Slower price growth in noncompensation costs, particularly malpractice costs, drove the slowdown in input prices as compensation price growth remained relatively stable.[20]

■ **Physicians and clinics.** Spending for physician and clinical services, the second-largest category of health spending, grew 5.9 percent in 2006 to $447.6 billion (Exhibits 1 and 2). This marked the slowest rate of growth since 1999 and contributed substantially to the slowdown in overall PHC spending in 2006. The 2006 growth rate was 1.5 percentage points slower than in 2005 and 1.9 percentage points below the average annual growth between 1999 and 2005. Growth in physician prices, as measured in the NHEA, increased 1.9 percent in 2006—1.5 percentage points slower than in 2005.[21] The slowdown in physician price growth was partly attributed to a freeze in the Medicare conversion factor for physician services in 2006. Private insurers appear to have followed the low Medicare price update in setting prices for privately financed physician services.

■ **Nursing homes and home health.** Spending for freestanding nursing homes grew 3.5 percent in 2006 to $124.9 billion, the slowest rate of growth since 1999 and a deceleration from 4.9 percent in 2005 (Exhibits 1 and 2). Slower growth in 2006 was driven in part by nursing home prices, which grew 3.0 percent following growth of 3.7 percent in 2005.[22] Nursing home employment and work hours (indicators of the amount of services used) both increased 1.1 percent in 2006, about the same rate as in 2005.[23] Nursing home services were financed primarily by public sources in 2006; Medicare and Medicaid together accounted for 60 percent of total nursing home spending.

Spending for freestanding home health services grew 9.9 percent to $52.7 bil-

lion in 2006, driven in part by slower home health price growth (Exhibits 1 and 2). The Producer Price Index for home health care services increased just 0.6 percent in 2006 following growth of 1.1 percent in 2005.[24] Despite the slowdown in 2006, home health continues to be the fastest-growing component of PHC spending, although its impact on total health care spending is limited because of its small share of total health spending (2.5 percent). The sustained high rate of growth in spending for home health care was driven partly by the continued movement of institutionalized people into home and community-based care.

■ **Medicare.** Medicare spending increased 18.7 percent in 2006 to $401.3 billion—an acceleration of 9.4 percentage points, which represents the fastest rate of growth in Medicare since 1981 (Exhibit 6). Much of this growth was due to the implementation of the Part D benefit. When the impact of prescription drug spending and administrative and net cost of insurance are removed, Medicare PHC spending increased only 6.0 percent in 2006, compared with 9.0 percent in 2005.

The slowdown in nondrug Medicare PHC spending in 2006 was influenced by slowing growth in nearly all services, with only durable and other nondurable medical products experiencing faster growth. A decrease in Medicare inpatient admissions contributed to the slowdown in Medicare hospital spending.[25] At the same time, Medicare physician spending growth slowed slightly in 2006, reflecting slower growth in Medicare FFS spending resulting from a 0.2 percent fee schedule increase compared with a 1.5 percent increase in 2005.

Medicare FFS spending (including Part D) growth accelerated rapidly in 2006, increasing 13.8 percent following growth of 7.7 percent in 2005. Part D prescription drug spending accounted for 74 percent of that increase. FFS Medicare spending without Part D increased just 4.0 percent in 2006, compared to 7.5 percent in 2005. The slowdown in non–Part D Medicare FFS spending growth was driven in part by a 3.8 percent decline in FFS enrollment in 2006. Even when Part D is included, Medicare FFS spending fell as a share of total Medicare spending, from 86 percent in 2005 to 82 percent in 2006, as it was outpaced by growth in MA spending.

MA spending increased dramatically (48 percent) in 2006—almost two and half times faster than in 2005. This rapid growth was primarily driven by a 25 percent increase in MA enrollment. MMA provisions that increased payments to MA plans gave incentives to those plans to increase enrollment by expanding their areas of coverage and offering additional benefits. MA plans include health maintenance organizations (HMOs), local and regional preferred provider organizations (PPOs), private FFS plans, and Medicare special-needs plans.

Because the mix of services is different between MA and FFS Medicare, the rapid increase in MA enrollment affects services differently. Two notable effects were an acceleration in spending for physician and clinical services and for administration and net cost of insurance, both of which have historically accounted for a greater share of spending than under FFS. MA payments for prescription drugs in-

EXHIBIT 6
National Health Expenditures (NHE), Amounts And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 1970–2006

Source of funds	1970[a]	1980	1990	2000	2003	2004	2005	2006
NHE, billions	$74.9	$253.4	$714.0	$1,353.6	$1,732.4	$1,852.3	$1,973.3	$2,105.5
Private funds	46.8	147.0	427.3	757.0	955.1	1,014.8	1,076.6	1,135.2
Consumer payments	40.4	127.0	369.8	648.0	827.7	880.7	932.7	980.0
Out-of-pocket payments	24.9	58.1	136.1	192.9	224.9	234.9	247.1	256.5
Private health insurance	15.5	68.8	233.7	455.1	602.8	645.8	685.6	723.4
Other private funds	6.4	20.0	57.5	109.0	127.4	134.1	143.9	155.3
Public funds	28.1	106.3	286.7	596.6	777.3	837.5	896.8	970.3
Federal	17.7	71.6	193.9	417.6	550.7	597.1	639.1	704.9
Medicare	7.7	37.2	109.5	224.4	281.5	309.3	338.0	401.3
Medicaid[b]	2.8	14.5	42.5	118.0	161.3	172.2	179.1	175.7
Other federal[c]	7.2	19.9	41.8	75.2	107.9	115.6	122.0	127.9
State and local	10.4	34.8	92.8	179.0	226.6	240.4	257.7	265.4
Medicaid[b]	2.4	11.5	31.1	83.6	110.3	119.9	134.4	134.9
Other state and local[c]	7.9	23.2	61.7	95.5	116.3	120.5	123.3	130.5
Total Medicaid[d]	5.3	26.0	73.7	201.6	271.6	292.0	313.5	310.6
Average annual growth from prior year shown								
NHE	10.5%	13.0%	10.9%	6.6%	8.6%	6.9%	6.5%	6.7%
Private funds	8.5	12.1	11.3	5.9	8.1	6.2	6.1	5.4
Consumer payments	8.0	12.1	11.3	5.8	8.5	6.4	5.9	5.1
Out-of-pocket payments	6.8	8.8	8.9	3.6	5.2	4.5	5.2	3.8
Private health insurance	10.2	16.1	13.0	6.9	9.8	7.1	6.2	5.5
Other private funds	12.2	12.2	11.1	6.6	5.3	5.2	7.3	7.9
Public funds	15.3	14.2	10.4	7.6	9.2	7.7	7.1	8.2
Federal	20.0	15.0	10.5	8.0	9.7	8.4	7.0	10.3
Medicare	–[e]	17.1	11.4	7.4	7.9	9.9	9.3	18.7
Medicaid[b]	–[e]	17.7	11.4	10.7	11.0	6.7	4.0	−1.9
Other federal[c]	9.7	10.7	7.7	6.0	12.8	7.1	5.5	4.9
State and local	10.2	12.8	10.3	6.8	8.2	6.1	7.2	3.0
Medicaid[b]	–[e]	16.8	10.4	10.4	9.7	8.7	12.1	0.4
Other state and local[c]	7.3	11.3	10.3	4.5	6.8	3.6	2.3	5.8
Total Medicaid[d]	–[e]	17.3	11.0	10.6	10.5	7.5	7.3	−0.9

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

NOTE: Numbers might not add to totals because of rounding.

[a] Average annual growth, 1960–1970.

[b] Includes State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

[c] Includes SCHIP (Title XXI).

[d] Subset of public funds; includes both the federal and the state and local portion of Medicaid.

[e] Not applicable; Medicare and Medicaid became effective in July 1966.

creased markedly in 2006 to $8.6 billion, up from $1.5 billion in 2005. MA-PD plans accounted for $6.4 billion in 2006, while other non–Part D MA drug spending accounted for the balance.

■ **Medicaid.** Medicaid spending decreased 0.9 percent in 2006, the first drop in Medicaid spending since the program was created in 1965 (Exhibit 6). The Medicaid program experienced major changes in 2006 as Medicare Part D replaced Medicaid drug coverage for dual eligibles. However, when Medicaid drug spending is removed, the remaining Medicaid PHC spending growth for 2006 turns positive—5.6 percent—yet still was slow compared with an 8.0 percent increase in 2005.

Medicaid spending growth slowed for all services except other PHC, which increased 12.9 percent in 2006 after an increase of 7.8 percent in 2005. The increase

in other PHC can be attributed to states' continued efforts to move long-term care treatment out of institutional settings and into home and community-based service options (which accounted for 60 percent of other PHC under Medicaid in 2006). The slower growth in all other Medicaid services reflected weaker growth in enrollment and continued cost containment initiatives by states.

Medicaid enrollment growth slowed to 0.2 percent in 2006—the smallest increase since 1998—primarily because of improved economic conditions and more-restrictive eligibility criteria.[26] Although many states continued to try to limit their Medicaid cost growth by implementing cost containment strategies, the pressure to abate costs has dissipated somewhat as the fiscal condition of many states has improved.[27] Some of the cost containment policies implemented by states included freezing or reducing provider payments, pharmacy controls, eligibility cuts, and increased fraud-and-abuse detection.[28]

■ **Private spending.** Total private health insurance premiums grew 5.5 percent in 2006, the slowest rate of growth since 1997 (Exhibit 6). The slower growth was attributable in part to a decline in private health insurance spending for prescription drugs and slower growth in underlying benefits. Enrollment growth in private insurance plans increased just 0.3 percent in 2006 (slightly faster than the 0.1 percent growth in 2005) and remained a minor contributor to the growth in premiums.

Benefit payments through private health insurance grew 6.0 percent in 2006, slower than the 6.9 percent increase in 2005. When prescription drug spending is removed (which fell 0.7 percent in 2006), private health insurance benefit growth accelerates slightly from 7.0 percent in 2005 to 7.3 percent in 2006. Private health insurance benefit payments for hospital, home health, and nursing home services grew faster in 2006 than in 2005; other sectors such as physician and clinical services, dental services, other professional services, and durable medical equipment experienced slower growth.

The net cost of private health insurance (the difference between premiums and benefits) grew 2.1 percent in 2006. The ratio of net cost to total premiums was 12.3 percent in 2006, below the most recent peak of 13.5 percent in 2003.

Out-of-pocket spending accounted for 12 percent of national health spending in 2006. This share has steadily declined since 1998, when it accounted for 15 percent of health spending; over the longer term, the share has fallen from 47 percent in 1960. *Out-of-pocket spending* is defined to include coinsurance, deductibles, payments from health savings accounts (HSAs), and amounts paid out of pocket for goods and services not covered by insurance. Enrollees' share of premiums for health insurance is not included in out-of-pocket spending but rather is included with private health insurance.

In 2006, out-of-pocket spending growth slowed to 3.8 percent (Exhibit 6). This deceleration was due to prescription drug spending, including the introduction of Medicare Part D; when drug spending is removed, out-of-pocket spending growth was 5.3 percent in 2006, close to the rates of increase in 2004 (4.5 percent)

and 2005 (5.2 percent). In each of the past three years (2004–2006), growth in out-of-pocket spending for health care was still less than the annual growth in nominal GDP and personal income, perhaps indicating that out-of-pocket spending had consumed less of the resources available to individuals.[29] However, when overall household spending (including out-of-pocket spending, private health insurance premiums, and Medicare premiums and payments) is calculated, the household burden of financing health care has remained fairly flat as a share of personal income since 2003.

Analysis Of Sponsors

Although the shares of spending for health services and supplies sponsored by businesses, households, governments, and other private sponsors remained relatively stable in 2006 (when looked at from an aggregate sponsor perspective), a longer-term view of health spending reveals major shifts in sponsor payments over time. The household share of spending for health services and supplies fell between 1987 and 2005, from 40 percent to 31 percent, where it remained in 2006.[30] In contrast, the share accounted for by governments experienced the opposite trend, increasing from 30 percent in 1987 to 40 percent in 2005 and 2006. This shift in funding between households and governments over this period was primarily due to the expanded role of the federal government in sponsoring Medicare and Medicaid. On the other hand, the share of health services and supplies paid for by businesses remained remarkably flat since 1987, between 25 and 27 percent.

Health spending growth by businesses slowed in 2006, increasing 5.7 percent to $496.8 billion—the slowest rate since 1997—because of a deceleration in employer payments for private health insurance, which resulted in part from the retiree drug subsidy under Medicare Part D (Exhibit 7). State and local government spending growth slowed as well, increasing 5.8 percent to $340.2 billion, following growth of 9.0 percent in 2005. Although some of this slower growth is attributable to the implementation of Medicare Part D, private health insurance premium growth for state and local governments as employers and state and local Medicaid spending also contributed.

Household spending grew 6.2 percent in 2006 and reached $611.6 billion. Faster growth in household spending was primarily attributable to increased Medicare premium payments associated with Medicare Part D. Although the movement into Part D plans of Medicare beneficiaries who previously had no drug coverage reduced household out-of-pocket payments for drugs, Part D premiums partly offset that reduction. Growth in federal government spending ($449.5 billion in 2006) for health care was 9.2 percent in 2006, up from 7.1 percent in 2005. The primary driver was growth in Medicare spending (largely as a result of the implementation of Medicare Part D), which increased 28.9 percent in 2006—more than double the rate of increase in 2005.[31]

EXHIBIT 7
Expenditures For Health Services And Supplies, By Type Of Service, Type Of Sponsor, And Source Of Funds, Calendar Year 2006

		Private funds ($)			Public funds ($)			
Spending category	Total ($)	Total[a]	Out of pocket	Private health insurance	Total	Medicare	Federal and state Medicaid[b]	Other public[c]
Health services and supplies (billions)	1,966.2	1,054.1	256.5	723.4	912.1	401.3	310.6	200.2
Type of service								
Personal health care (PHC)	1,762.0	963.8	256.5	634.6	798.2	381.0	287.5	129.7
Hospital care	648.2	285.6	21.4	234.8	362.6	187.2	111.2	64.3
Professional services	660.2	426.1	101.9	286.6	234.1	104.6	84.9	44.6
Physician and clinical services	447.6	294.5	46.2	219.7	153.1	92.1	31.8	29.2
Other prof. services	58.9	39.6	15.1	21.5	19.3	12.4	3.6	3.3
Dental services	91.5	86.0	40.6	45.3	5.5	0.1	4.6	0.7
Other PHC	62.2	5.9	–[e]	–[e]	56.3	–[e]	44.9	11.4
Home health and nursing home	177.6	59.9	38.9	15.3	117.7	40.6	72.0	5.1
Home health[d]	52.7	13.0	5.9	6.0	39.7	19.8	17.7	2.1
Nursing home[d]	124.9	46.8	32.9	9.3	78.1	20.8	54.2	3.0
Retail outlet sales of medical products	276.0	192.3	94.4	97.9	83.8	48.6	19.5	15.7
Prescription drugs	216.7	142.7	47.6	95.1	74.0	39.5	19.4	15.1
Durable medical equipment	23.7	16.2	13.3	2.9	7.5	7.0	0.0	0.5
Other nondurable medical products	35.6	33.4	33.4	–[e]	2.2	2.2	–[e]	0.0
Program admin. and net cost of private health insurance	145.4	90.2	–[e]	88.8	55.2	20.2	23.1	11.8
Gov. public health activities	58.7	–[e]	–[e]	–[e]	58.7	–[e]	–[e]	58.7
Sponsor of health care[f]								
Health services and supplies	1,966.2	1,052.0	256.5	721.3	914.2	387.4	320.2	206.6
Private	1,176.5	923.1	256.5	592.4	253.4	221.1	–[e]	32.3
Private business	496.8	387.1	–[e]	381.1	109.7	77.3	–[e]	32.3
Household	611.6	467.8	256.5	211.3	143.8	143.8	–[e]	–[e]
Other private revenues	68.2	68.2	–[e]	–[e]	–[e]	–[e]	–[e]	–[e]
Public	789.6	128.9	–[e]	128.9	660.8	166.3	320.2	174.2
Federal government	449.5	24.3	–[e]	24.3	425.2	156.4	181.3	87.5
State and local government	340.2	104.6	–[e]	104.6	235.6	9.9	138.9	86.8

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

NOTE: Numbers might not add to totals because of rounding.

[a] Includes other private funds.

[b] Includes Medicaid State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

[c] Includes SCHIP (Title XXI).

[d] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

[e] Not applicable.

[f] Medicaid buy-ins for Medicare eligibles ($9.6 billion) are allocated to Medicaid. In the traditional National Health Expenditure Accounts (NHEA), they are included with Medicare. Differences in total private health insurance and total public funds are due to the reallocation of the retiree drug subsidy ($2.1 billion) from private health insurance to Medicare. The other public difference is due to the reallocation of the state phase-down payment ($6.4 billion) from Medicare to state and local governments.

[g] The data for federal government Medicare equal Trust Fund interest income and federal general revenue contributions to Medicare less the net change in the Trust Fund balance.

Discussion And Conclusions

Growth in health care spending was 0.2 percentage point faster in 2006 than in 2005 and outpaced nominal GDP by 0.6 percentage point. Although growth in most health care services slowed in 2006, retail prescription drug spending grew at a faster rate, reversing a slowing trend that began in 2000. This change in the prescription drug spending trend occurred as the financing of retail drug purchases was substantially affected by the implementation of Medicare Part D in January 2006. The shift in the funding of prescription drug purchases resulted in large, one-time impacts in spending growth rates in 2006, including the fastest increase in Medicare spending since 1981 (18.7 percent), while private health insurance spending grew at its slowest rate since 1997 (5.5 percent), and Medicaid spending declined for the first time (−0.9 percent).

As the health sector continues to evolve, it will be critically important to understand how it affects households, business, governments, and health care providers. The unique nature of 2006 gives us a glimpse of this evolution and its effect. Future changes will likely have different impacts, some short-term and others lasting, but each will help determine the pace at which health care continues to place demands on Americans' economic resources.

The authors thank the other members of the National Health Expenditure Accounts Team: Mary Carol Barron, Dave Lassman, Anne Martin, Randy Matsunaga, Pat McDonnell, Olivia Nuccio, Nate Singer, Benjamin Washington, and Lekha Whittle. The opinions expressed here are the authors' and not necessarily those of the Centers for Medicare and Medicaid Services. The authors also thank Richard Foster, Paul Spitalnic, Mark Freeland, John Poisal, Sean Keehan, Cathy Curtis, Sue Todhunter, and anonymous peer reviewers for their helpful comments.

NOTES

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